Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: NORTHWEST TEXAS HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-08-6984-01
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO. Rep Box # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare MAR rate for this service is $46.98 times 140% is $65.77. We only received $25.00 in payment for this service. We request the insurance carrier pay the remaining balance of $40.77."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - $40.77
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Carrier request the Division review Requestor's claim under its general obligations to adjudicate disputes in accordance with relevant statutory provisions [including, but not limited to Texas Labor Code §§ 413.011 and 413.031(c)] and commissioner rules [including, but not limited to 28 TAC §§ 134.1, 134.202, 134.302, 134.303, 134.401 and 134.500 series], including applicable CMS payment policies."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/6/2008	O, 150, 900-030, 193, 920-002, 850-243, M, 900-068	Outpatient Radiological Services	$40.77	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective January 17, 2008 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- O-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
- 150-Payer deems the information submitted does not support his level of service. $25.00.
- 900-030-CV: This charge was reviewed through the clinical validation program.
- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- 920-002- In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
- 850-243-CV: The recommended allowance reflects a fair, reasonable and consistent methodology or reimbursement purusuant to the criteria set forth in Section 413.011(D) of the Texas Workers Compensation Act.
- M-NO MAR $25.00.
- 900-068-CV: Additional reconsideration of the bill and submitted documentation does not support additional payment.

2. This dispute relates to outpatient radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, which states that "Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services."
3. This dispute relates to diagnostic radiology services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective January 17, 2008, 33 TexReg 428, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues."… This request for medical fee dispute resolution was received by the Division on July 29, 2008. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).
7. Division rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... The requestor's position statement asserts that Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare MAR rate for this service is $46.98 times 140% is $65.77." However the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Additionally, the requestor did not provide documentation, such as Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv), and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	12/22/2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.